



# **RADIATION MACHINE REGISTRATION APPLICATION PART A - GENERAL FACILITY INFORMATION AND AGREEMENT**

State Form 9977 (R4 / 1-04)

Indiana State Department of Health  
Indoor and Radiologic Health

**FOR OFFICIAL USE ONLY:** ☐ New Facility ☐ Update Facility ☐ Moving Facility

*In accordance with regulations promulgated under authority of IC 16-41-35, each person having one or more radiation machines shall apply for registration of the machines with the Indiana State Department of Health before the operation of the machines. This registration must also be updated whenever the information contained in it changes. For all non-industrial facilities, this registration must also be upgraded annually.*

**PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION**

## **FACILITY INFORMATION**

*If the facility has no name, list the doctor's name. If the mailing address is different than the physical address of the facility, list both addresses, clearly indicating which is the mailing address and which is the physical address. If correspondence should be sent in care of some other facility, list that facility in the facility name block, as in "c/o Memorial Hospital". The radiation safety officer must be an employee of the facility and is the individual responsible for radiation safety at the facility in case of overexposures or other problems. All correspondence will be sent to the Radiation Safety Officer. If this is a previously unregistered facility, put "New" for the Facility Registration number.*

Facility Registration number	Name of facility	Date (month, day, year)
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Address (number and street)

City, state, 9 digit ZIP code (mandatory)

Facility telephone number

County of practice

Name of Radiation Safety Officer (RSO)

RSO telephone number

Select type of facility:

☐ X - Dental

☐ 3 - Educational (Schools / Colleges)

☐ 6 - Veterinarian

☐ 1 - Hospital

☐ 4 - Podiatric

☐ 7 - Industrial

☐ 2 - Physicians / Clinics / Mobile

☐ 5 - Chiropractic

☐ 8 - Nursing Homes /

Other \_\_\_\_\_

## **REGISTRATION AGREEMENT**

*The following agreement should be signed by a person who has legal responsibility for the radiation machines at the facility (i.e., owner, hospital administrator, corporation director, etc.)*

I understand that failure to comply with IC 16-41-35 or 410 IAC 5 may result in revocation of my machine registration.

Printed name of responsible individual

Signature of responsible individual

Date (month, day, year)

Return Parts A, B and C of this application:

**Indiana State Department of Health  
Indoor and Radiologic Health  
2 North Meridian Street, Fifth Floor  
Indianapolis, IN 46204-3006**

If you have any questions, call 317/233-7147 and ask for the Radiation Machine Compliance Coordinator.



# **RADIATION MACHINE REGISTRATION APPLICATION PART B - SPECIFIC FACILITY INFORMATION**

State Form 9977 (R4 / 1-04)

Indiana State Department of Health  
Indoor and Radiologic Health

## **PERSONNEL RADIATION EXPOSURE MONITORING (All Facilities)**

Name of personnel monitoring device supplier	Types of personnel monitoring devices used
Number of persons monitored for WHOLE BODY exposure	
Number of persons monitored for EXTREMITY exposure	
Number of persons monitored under 18 years of age	

## **MAMMOGRAPHY FACILITY STAFF QUALIFICATIONS (Mammography Facilities Only)**

### **Interpreting Physician Requirements**

Are all interpreting physicians ABR, AOBR, or ACR certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all interpreting physicians completed or taught 40 hours of postgraduate instruction in mammography interpretation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all interpreting physicians completed or taught 15 hours minimum postgraduate work in mammography interpretation in the past 36 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do all interpreting physicians read at least 10 mammography exams per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do all interpreting physicians provide written statements as required by 410 IAC 5-6.1-127?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### **Consulting Physician Requirements**

Does the consulting physician meet all the requirements of an interpreting physician as listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the consulting physician check the procedures manual annually?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the consulting physician verify the performance of the mammography machines and mammographers monthly?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### **Mammographer Requirements**

Are all mammographers Indiana state certified diagnostic x-ray machine operators in the "General" category?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all mammographers completed at least 10 hours of continuing education in mammography in the past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all mammographers passed the ARRT Mammography examination or completed 10 hours of specialized training in mammography (positioning, compression, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have all mammographers completed an orientation program based on the procedures manual?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## **STAFF QUALIFICATIONS (Human Use Facilities Only [Medical, Hospital, Chiropractic, Podiatric, Dental, etc.])**

List the number of each of the following types of personnel employed by the facility.

Licensed Practitioners:	Students in the Board-approved OJT program:
Dental Hygienists	Students in the other approved education programs:
State Certified Diagnostic X-Ray Machine Operators	Other persons taking radiographs:



# Indiana State Department of Health

## RADIATION MACHINE REGISTRATION APPLICATION Part C - Radiation Machine Information

### Facility Information

Date: \_\_\_\_\_ Fac. Reg. #: (From Part A): \_\_\_\_\_ Facility Name (From Part A): \_\_\_\_\_

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### Machine Information

List each radiation machine in your facility on a separate line in the table and provide all information requested

Tube Number	Type of Machine (Code from table below)	Location in Facility (Room Number)	Machine Control Manufacturer	Number of Tube Heads	Beam Collimation (Check only one)	Maximum kVp rating	Maximum mA rating	Utilization Mode (Check Only One)	Date Manufactured	Date Installed
					<input type="checkbox"/> Adjustable <input type="checkbox"/> Cone <input type="checkbox"/> Diaphragm <input type="checkbox"/> None <input type="checkbox"/> Other			<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Portable <input type="checkbox"/> Not in use		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> Cone <input type="checkbox"/> Diaphragm <input type="checkbox"/> None <input type="checkbox"/> Other			<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Portable <input type="checkbox"/> Not in use		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> Cone <input type="checkbox"/> Diaphragm <input type="checkbox"/> None <input type="checkbox"/> Other			<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Portable <input type="checkbox"/> Not in use		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> Cone <input type="checkbox"/> Diaphragm <input type="checkbox"/> None <input type="checkbox"/> Other			<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Portable <input type="checkbox"/> Not in use		
					<input type="checkbox"/> Adjustable <input type="checkbox"/> Cone <input type="checkbox"/> Diaphragm <input type="checkbox"/> None <input type="checkbox"/> Other			<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Portable <input type="checkbox"/> Not in use		

### Radiation Machine Type Codes:

- |  |                               |                             |                         |
|--|-------------------------------|-----------------------------|-------------------------|
| 1 Therapy Simulator                        | 8 Particle Accelerator        | 15 Fluoroscopy (undertable) | 22 Dental, Panoramic    |
| 2 Superficial X-ray Therapy (up to 150 kV) | 9 Tomography                  | 16 Fluoroscopy (abovetable) | 23 Dental, Multipurpose |
| 3 Cobalt-60 Therapy                        | 10 Computer Tomography (Head) | 17 Fluoroscopy/Radiography  | 24 TMJ Unit             |
| 4 Electron Beam Only Therapy               | 11 Computer Tomography (Body) | 18 C-Arm Fluoroscopy        | 25 Mobile Van           |
| 5 Supervoltage Therapy (1 - 11.99 MEV)     | 12 Radiography                | 19 MRI Unit                 | 26 Industrial X-ray     |
| 6 Megavoltage Therapy (12+ MEV)            | 13 Mammography                | 20 Dental, Cephalometric    | 27 Laboratory X-ray     |
| 7 Orthovoltage Therapy (151-999 kV)        | 14 Digital Radiography        | 21 Dental, Intraoral        | 28 Other _____          |